No. 84-325 and 84-356

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

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BRIEF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES, THE COUNCIL OF STATE GOVERNMENTS, THE NATIONAL LEAGUE OF CITIES, THE NATIONAL ASSOCIATION OF COUNTIES, THE U.S. CONFERENCE OF MAYORS, AND THE INTERNATIONAL CITY MANAGEMENT ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLEE

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QUESTION PRESENTED

Whether the Employment Retirement Income Security Act (ERISA) preempts state laws requiring health insurance policies to provide particular minimum benefits to the insured.

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INTEREST OF AMICI CURIAE

The *amici* are organizations whose members include state, county and municipal governments and officials located throughout the United States. *Amici* and their members have a vital interest in legal issues that affect

the powers and responsibilities of state and local government.

The question in this case—whether the Employee Retirement Income Security Act (ERISA) preempts all state laws requiring health insurance policies to provide minimum mental health benefits to the insureds—is one of vital importance to *amici* and their members.

States are deeply concerned that citizens suffering from crucial medical problems be covered by insurance and receive treatment. Many people first discover in the middle of a medical crisis that their health insurance policy does not protect them from the ravaging cost of medical care. To close unacceptable gaps in private health insurance coverage, 49 states now mandate various forms of minimum coverage in all health insurance policies sold in the state.[1] Mandated benefits include neo-natal care, dependent care, coverage for catastrophic illness and coverage for alcohol and drug problems.[2] In addition, Massachusetts and at least 27 other states mandate insurance coverage for mental illness.

States have an additional interest in providing for expanded insurance coverage of serious health problems through insurance. Advances in medical science have created a need for more private and public health programs. The demand for high quality health care is enormous and growing, but states have a limited fiscal capacity to meet even the present call for services. Nor is the federal government meeting the need for servics. The state policy at issue here accommodates this need by promoting a better level of health care for citizens and earlier treatment for mental illness and other medical problems. Moreover, the state policy accomplishes this without additional overwhelming economic burdens being placed on state and local governments, which already spend approximately $40 billion a year on health and medical care.[3]

[1] Blue Cross Association: G. Scandler, Total Number of States With Mandated Coverage (1984) (unpublished report available at Blue Cross Association, Washington, D.C.).

[2] Blue Cross Association: Legal Affairs Bulletin and G. Scandler, Total Number of States With Mandated Coverage (1984) (unpublished report available at Blue Cross Association, Washington, D.C.).

The foregoing shows that the legal issues presented by this case are of great importance to state governments, especially since a decision adverse to Massachusetts would eviscerate the mandated benefit laws of no less than 49 states. Thus *amici* are submitting this brief to assist the Court in its resolution of this action.[4]

STATEMENT OF THE CASE

Amici agree with the statement of facts submitted by the Commonwealth of Massachusetts. In addition, *amici* wish to call the Court's attention to the following facts, which demonstrate the importance of this case to state and local government:

A. Health Insurance, Which Is an Essential Means of Covering Health Costs, Often Has Gaps In Coverage And Appears To Be Preeminently Obtained By Means Other Than Collective Bargaining Agreements.

1. Health care cost $286.6 billion nationally in 1981. This was an estimated 9.8 percent of the gross national product.[5] Because the cost also averaged $1,225 per person, it is plain that few families could afford the entire

[3] Total state and local government expenditures for health and medical care in 1981 were $38.6 billion. Health Insurance Ass'n. of America, *Source Book of Health Insurance Data*, 1982-83, Table 4.1. The public health programs of State health agencies cost $4.9 billion a year. This does not include funds expended for public health purposes by other state agencies. Nor does it include expenditures of local health departments. Health Insurance Ass'n. of America, *Source Book of Health Insurance Data*, 1982-83, Table 4.7.

[4] Pursuant to Rule 36, the parties have consented to the filing of this *amicus* brief. Their letters of consent have been lodged with the Clerk of the Court.

[5] Health Insurance Ass'n. of America, *Source Book of Health Insurance Data, 1982-83*, Table 5.1 and Table 5.2.

costs of health care unaided.[6] An essential way of covering these costs is through health insurance.

By the end of 1981, more than 188 million Americans, or 84 percent of the civilian non-institutional population, were protected by some form of private health insurance.[7] With the growth of private health insurance plans, however, states have become increasingly concerned about the quality and the extent of coverage that these plans provide to insured individuals.

It has been found that private plans too often have serious gaps in coverage, gaps which exist until states mandate the necessary coverage. For example, neo-natal care or newborn coverage was not provided in most health insurance policies until mandated by law. Newborn babies usually were not covered by insurance until 10 to 30 days after birth. Parents of newborn children with congenital medical problems often found themselves uninsured and faced with devastating medical bills.

Gaps in coverage have also been found in other important medical areas, including maternity care, catastrophic illness, mental health, and alcohol and drug problems. A major reason for the gaps in coverage is the problem of adverse selection of risks. This problem exists when particular forms of coverage are optional. To illustrate, persons of an age where they do not expect catastrophic illness may not purchase optional insurance providing for coverage of such illness. This limits the pool of applicants for the insurance and drives up the price to prohibitive levels. A state law which mandates coverage for catastrophic illness spreads the risks and costs over a wider pool of insureds, and thereby causes the insurance to be available at a reasonable price.

2. Private health insurance plans are predominantly group plans, and it seems highly likely that vast numbers

[6] *Source Book of Health Insurance Data, supra,* Table 5.3.

[7] *Source Book of Health Insurance Data, supra,* at 7 and Table 1.1.

of individuals covered by health insurance—probably even the overwhelming majority of such persons—have not received their coverage as a result of collective bargaining agreements. This is indicated by statistics. As said above, by the end of 1981 over 188 million Americans had some form of private health insurance. Although over 137 million of these people were members of group plans by 1980,[8] in 1978, the most recent year for which statistics are available, labor union membership nationally was only 21,784,000.[9] Furthermore, by 1979, when 43.6 million full-time private sector employees were covered by group health plans, only 14.01 million of them were union members with a right of collective bargaining. Similarly, though by 1979 11.4 million full-time government workers were covered by group health plans, in 1980 only 4.9 million full-time government employees were union members with a right of collective bargaining.[10] Thus though definitive statistics are not available, it seems obvious that most covered individuals obtain insurance not because of collective bargaining agreements, but because of voluntary provision by an employer or by means of self purchase.

B. Massachusetts Adopted Section 47B Only After Careful Consideration of the Problems of Inadequate Coverage.

In 1973, Massachusetts enacted a law requiring any general health insurance policy to provide minimum bene-

[8] In 1981, 855,000 group plans were on file nationally. U.S. Dept. of Labor, *Report of Labor Management Services Administration* 32 (1982 report).

[9] U.S. Dept. of Comm., *Statistical Abstract of the United States, 1984,* 104th ed. No. 155, Persons With Health Care Coverage by Type of Coverage; Number 729, Employed Workers in Labor Organizations; No. 728, Labor Organization Membership; No. 726, Labor Union and Employee Association Membership.

[10] U.S. Dept. of Labor, *Group Health Insurance Coverage of Private Full-Time Wage and Salary Workers, 1979* (1981).

fits for beneficiaries suffering from mental health conditions (Massachusetts Gen. Laws ch. 175, § 47B).[11] This law was adopted only after extensive legislative consideration and hearings, and a lengthy report of the Legislature's Joint Committee On Insurance.[12] It was enacted to meet the serious health problem caused by inadequate and delayed treatment of mental illness.

Massachusetts was acting "on some grave problem areas since years were passing without any policy emerging from Washington."[13] The legislature was especially concerned with the spread of mental illness among workers and among the poor. However, because mental illness strikes indiscriminately, the coverage "safeguards the . . . young and old, rich and poor, against the burden-

[11] The law requires that minimum mental health care benefits for inpatient care must be provided in all general health insurance policies. And, to the extent of $500 over a 12-month period, outpatient care must also be covered, if provided by comprehensive mental health organizations, licensed or accredited hospitals or community mental health centers. See Appendix, *infra*.

[12] The Report of the Joint Committee on Insurance was carefully considered by the courts below in reaching their decision. For example, the Supreme Judicial Court of Massachusetts in its March 24, 1982 opinion stated in footnote 24:

> "A report of the Joint Committee on Insurance of the General Court, incorporated into the findings of the judge below, demonstrates that the Legislature was concerned with the spread of mental illness among workers and among the poor. In the committee's view, mental health insurance programs would encourage community-based, out-patient care and decrease the need for institutionalization. 'Mental illness strikes indiscriminately among young and old, rich and poor. A need therefore exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today.' General Court Joint Committee on Insurance, Advances in Health Insurance in Massachusetts 9 (1974)."

[13] Report on the legislation, the Joint Committee on Insurance of the Massachusetts General Court. Joint Appendix of the Parties (hereafter J.A.)-427.

some cost of professional mental health services and care."[14] The legislature found that inpatient institutional care in mental hospitals was often obsolete and in many cases very damaging.[15] But "[o]utpatient care given at a local community mental health center . . . enables the mentally ill to receive adequate treatment without costly institutionalization . . ."[16]

The Committee noted that because only one percent of the people of the Commonwealth were previously insured for outpatient care, community mental health centers had been publicly supported, costing Massachusetts taxpayers millions of dollars annually. However, "[b]y making mental health care coverage mandatory, Massachusetts can continue the thrust toward community-based care . . . increas[ing] the availability for treatment in privately run mental health centers but sav[ing] the taxpayers money as well."[17]

Mental health insurance, the Committee found, can be offered at a reasonable cost only when included in large group policies. Also, for the cost to be reasonable, insurance for mental illness has to be a mandatory feature of all policies sold in the state. "An optional offer to cover mental illness is contrary to the most basic principle of insurance—that of 'risk sharing'."[18]

The committee also found that insurance coverage for mental health was not abused where it was offered and

[14] Report on the legislation, *supra*, J.A.-430-431.

[15] Report on the legislation, *supra*, J.A.-431.

[16] Report on the legislation, *supra*, J.A.-432. Deinstitutionalization of the mentally ill and mentally retarded is a policy that has received considerable support and encouragement from the federal government. *See, e.g., Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981).

[17] Report on the legislation, *supra*, J.A.-432.

[18] Report on the legislation, *supra*, J.A.-433.

that it decreased non-psychiatric medical care for so-called physical ailments. A study by the Group Health Association in Washington, DC, for example, demonstrated that providing mental health services substantially reduced the amount of nonpsychiatric care that was needed.[19] The patients who received outpatient psychiatric treatment required a significantly smaller amount of services from physicians and fewer laboratory and X-ray procedures.

The Committee concluded that to enlarge the community health care system "and make [outpatient treatment] available to millions of Massachusetts residents mental health insurance must be mandatory . . ." [20]

SUMMARY OF ARGUMENT

I.

Forty-nine states have enacted laws which require health insurance companies to include various types of medical benefits in their insurance policies. The states passed these laws to protect their citizens against medical problems which are a menace to public health. If the laws are held preempted, millions of citizens will be left unprotected against these problems.

However, when it enacted ERISA, Congress did not intend to preempt the state laws. This is not only the position of *amici*, but is the position that has been expressed to the Court by the federal government, whose law is involved.

Such position is supported by ERISA's broad savings clause, under which state laws regulating insurance are exempted from preemption. Moreover, when it enacted ERISA, Congress was aware of state insurance laws requiring carriers to provide various benefits, yet it nevertheless inserted the broad savings clause exempting state insurance laws from preemption. In so doing, Congress adhered to its traditional position that regulation of insurance is for the states.

[19] Report on the legislation, *supra*, J.A.-435.

[20] Report on the legislation, *supra*, J.A.-437.

Furthermore, Congress did not deal in any way with the substantive content of health insurance policies when it enacted ERISA. Thus, if state mandated benefit laws such as Section 47B are struck down, citizens will have *no* government protection, be it federal *or* state. Nor will vast numbers of citizens obtain whatever protection can be secured through collective bargaining. For millions of citizens—very likely the vast majority of those who are covered by health insurance—do not obtain their coverage by means of collective bargaining agreements.

Finally, appellants argue that in the absence of preemption there will be a lack of uniformity among state mandated benefit laws. Their argument is addressed to the wrong forum. It should be addressed to Congress, which contemplated non-uniformity when it inserted the savings clause exempting state insurance laws from preemption.

II.

State mandated benefit laws are not preempted by the NLRA. Congress did not intend the NLRA to supersede state laws regulating insurance. And it is inconceivable that Congress intended the NLRA to strip states of their historic power to safeguard the public health—a result which would ensue if there is preemption here.

Moreover, there also is no preemption under the tests the Court often uses in labor matters. First, laws such as Section 47B are deeply rooted in local feeling and responsibility because they protect the local public health. Second, they do not affect any economic weapon (such as strikes) used by labor or management.

ARGUMENT

I. STATE LAWS MANDATING MINIMUM HEALTH INSURANCE BENEFITS ARE NOT PREEMPTED BY ERISA

A. Introduction

This case presents a fundamental question of preemption which deeply concerns state and local governments. The principal issue is whether ERISA prohibits states from protecting the health of their citizens by requiring that health insurance policies provide minimum benefits for such serious problems as mental illness, catastrophic illness, medical care for newborn babies, and dependency on alcohol or drugs. Massachusetts and 48 other states have enacted laws that mandate minimum benefits because these problems are a menace to public health, there have been gaps in insurance coverage, and the laws reduce the costs of insurance because of a wider sharing of risk.

Moreover, as this Court has recognized, Congress, when it enacted ERISA, did not deal in any way with the substantive content of health insurance plans. *Shaw v. Delta Air Lines, Inc.*, 103 S.Ct. 2980, 2897 (1983). Instead, Congress left the regulation of insurance to the states, which have traditionally exercised such power of regulation. There is thus no conflict between ERISA and Section 47B of the Massachusetts law. To the contrary, if Section 47B were held preempted, tens of millions of citizens would be left without any protective regulation, federal *or* state. Thus, in enacting mandated benefit laws, states are acting in pursuit of the legitimate and traditional state purpose of protecting the health and welfare of their citizens. In this regard, statutes such as Section 47B exemplify state innovation designed to solve significant social problems without reliance on Washington for help.

B. Congress Saved State Insurance Laws From Preemption by ERISA

1. As this Court recently stated, "Preemption of state law by federal statute or regulation is not favored 'in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained.'" *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). "Persuasive reasons" for preemption exist when there is an actual conflict between state and federal law, i.e. when "compliance with both federal and state regulations is a physical impossibility," *Florida Lime and Avocado Growers Inc. v. Paul*, 373 U.S. 132, 142-143 (1963), or when state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).

There are no such "persuasive reasons" for preemption in this case. Though Section 514 of ERISA provides that all state laws that "relate" to employee benefit plans are preempted,[21] this clause is followed by a broad savings clause which exempts state insurance laws from preemption: "Except as provided in subparagraph (B), nothing in the subchapter should be construed to exempt or relieve any person from any law of any state which regulates insurance. . . ." [22] Thus, instead of *preempting* state laws regulating insurance, Congress has expressly said that they are *free* of preemption.[23]

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[21] ERISA Section 514(a), 29 U.S.C. § 1144(a). See Appendix, *infra*.

[22] ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). See Appendix, *infra*.

[23] Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) provides that no state can deem an employee benefit plan to be an insurance company, or to be engaged in the business of insurance, for purposes of "regulating" insurance. This "deemer" clause simply prohibits

The federal government, whose law is involved here, has agreed that state laws which require insurance policies to provide mental health benefits are not preempted by ERISA. It has said these laws are excluded from preemption by the savings clause even though they indirectly affect employee benefit plans which purchase the insurance policies.[24] As the Solicitor General said:

> "This savings provision would be meaningless unless it saved from preemption state laws regulating insurance which also indirectly regulate employee benefit plans, since no other state law regulating insurance would be subject to preemption under the Act even in the absence of the savings provision. Chapter 57 obviously "regulates insurance," and thus the court correctly found that Congress intended that law and others like it to remain effective regardless of ERISA's otherwise broad preemption of state laws relating to plans. . . .[25]
>
> The fact that the purchaser of insurance is an employee benefit plan is immaterial; Congress did not intend to confer any special exemption or privilege on them as insurance buyers. Insurance sales to them must conform to the same rules as those to any

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the state from regulating employee welfare benefit plans by calling them insurers. It does not prohibit the state from regulating bona fide insurers when they are doing business with employee benefit plans. Note, *ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws*, 78 *Col. L. Rev.* 1536, 1541 (1978).

[24] Memorandum for the United States as *amicus curiae*, filed March 27, 1978, at the request of the Court, *Wadsworth v. Whaland* and *Dawson v. Whaland*, Nos. 77-765 and 77-772, October Term 1977. *Wadsworth v. Whaland*, 561 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 98 (1978).

[25] The issue in *Wadsworth v. Whaland* was whether a New Hampshire statute, Chapter 57 of N.H. Rev. Stat. Ann. of Laws of 1976, which mandates mental health benefits in group health insurance policies, was preempted by ERISA.

> other insurance buyer, and if a state determines, as New Hampshire has done here, that all group health insurance sold in the state must provide coverage for mental and emotional disturbance, the plans may purchase no other. . . .
>
> "Congress preserved authority in the states to regulate insurance, and if petitioners find the result burdensome their recourse is to Congress, or to the state legislatures, rather than to this Court." [26]

The position of *amici*, and that expressed by the Solicitor General, is supported by the legislative history surrounding the passage of ERISA. In 1974, the year ERISA was enacted, at least 16 states had insurance laws that mandated particular health benefits in insurance policies.[27] Congress was aware of the functions and scope of such laws, yet specifically exempted state laws regulating insurance from the preemption clause of ERISA.[28] Moreover, Congress did not seek to deal in any way with the substantive content of insurance—which is what laws like Section 47B *do* deal with.[29] Rather, as this Court has recognized, Congress intended only to establish reporting, disclosure and fiduciary requirements for pension and welfare benefit plans.[30]

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[26] Memorandum for the United States, *supra* at 7-9. (Footnote added.)

[27] Blue Cross Association: G. Scandler, Total Number of States With Mandated Coverage (1984) (unpublished report). The earliest mandated benefit plans were adopted in the late 1960s. By 1974, 16 states had enacted newborn coverage, 4 states had enacted mental health coverage and 5 states had alcohol abuse coverage.

[28] *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 98 (1978). *Insurance Commissioner v. Metropolitan Life Ins. Co.*, 296 Md. 334, 463 A.2d 793 (1983).

[29] *Shaw v. Delta Air Lines, Inc.*, 103 S.Ct. 2890, 2896 (1983).

[30] Appellants argue that laws such as 47B are preempted because this Court has said ERISA's preemption provision is very broad and even covers subjects not dealt with in ERISA. Brief for Appellant

2. Congressional intent to leave states free to regulate the content of insurance policies is further indicated by the fact Congress has traditionally supported—and when necessary re-established—state regulation of insurance. From the 1869 decision in *Paul v. Virginia*, 8 Wall. 168 (1869), to the 1944 decision in *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533 (1944), insurance was considered not to be interstate commerce and was therefore regulated by the states. When the Court ruled in *South-Eastern Underwriters*[31] that insurance *is* interstate commerce, a ruling which made insurance susceptible to federal regulation instead of state regulation, Congress quickly passed the McCarran-Ferguson Act[32] to give support to existing and future state systems for regulating and taxing insurance. *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408, 429 (1946).

The Act specifically allows states to regulate the "business of insurance." The business of insurance is precisely what is regulated by state laws requiring health insurers to provide specified benefits to their insureds. This is only common sense. It is also supported by precedent. For the Court has said "[T]he core of the 'business of insurance'" encompasses "[t]he relationship between insurer and insured, the type of policy which could be issued. . .", *Securities and Exchange Comm'n v. National Securities, Inc.*, 393 U.S. 453, 459-460, and that the business of insurance includes "the contract between the insurer and the insured." *Group Life & Health Insur-*

Metropolitan Life Insurance Company at p. 13. But the savings clause broadly excepts insurance from the preemption provision, and the Court's statements which indicate the breadth of the preemption provision were not intended to indicate a narrow scope for the savings clause. To the contrary, the Court specifically said that ERISA's concerns are *limited* by the savings clause. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, f.n. 19 (1981).

[31] *United States v. South-Eastern Underwriters Ass'n, supra*, 322 U.S. 533 (1944).

[32] 15 U.S.C. Section 1011 *et seq.* See Appendix, *infra*.

ance Co. v. Royal Drug Co., 440 U.S. 205, 215 (1979). These matters were summarized in *Securities and Exchange Comm'n v. National Securities, Inc.*, 393 U.S. 453:

> "Congress was concerned with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement—these were the core of the 'business of insurance'. Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policy holder. Statutes aimed at protecting or regulating this relationship, directly or indirectly are laws regulating the business of insurance." *Securities & Exchange Comm'n. v. National Securities, supra* at 460.[33]

3. If the Court were to find preemption here, millions of citizens would be left without necessary protections. As pointed out above, in the absence of state laws requiring particular benefits, there are gaps in health insurance coverage and certain forms of health insurance are prohibitively expensive. Crucial coverage such as neo-natal care, care of mental health problems, and catastrophic illness insurance are either unobtainable or unobtainable at affordable prices. Furthermore, Congress did not deal with this problem in ERISA, as ERISA does not touch the substantive content of health insurance policies. Thus citizens will be deeply and adversely affected if laws such as Section 47B are struck down.

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[33] Appellants claim that, because it is intended to protect public health, Section 47B does not regulate insurance. The claim is plain error. Section 47B protects the public health *by* regulating insurance.

Moreover, vast numbers of citizens—probably even the overwhelming majority of those who possess some form of health insurance—will not secure whatever protections can be obtained through collective bargaining. Although defendants lay much stress on their claim that laws such as Section 47B allegedly interfere with the results of collective bargaining, the available data indicates that huge numbers of citizens obtain health insurance by means other than such bargaining. They obtain it either by unilateral action of an employer or by self-purchase. That collective bargaining is irrelevant to most people in connection with health insurance is shown by the statistics. In 1979, 14 million full-time union members with a right of collective bargaining were covered by health insurance policies, but shortly thereafter the total number of individuals with health insurance was almost 14 times greater than this: it was 188 million. As well, 43 million full-time private sector employees were covered by group health plans in 1979, but only 14 million of them were union members with a right of collective bargaining. And 11 million full-time government workers were covered by group health plans by 1979, though in 1980 only 5 million full-time government employees were union members with a right of collective bargaining.[34]

The fact that a finding of preemption will leave huge numbers of people without crucial types of medical benefits counsels strongly against such a ruling, for it would be very odd if a law enacted to protect workers—ERISA—were to result in their being deprived of crucial protections. It would be equally odd if ERISA were held to knock out the protective laws of 49 states dealing with a subject that Congress did not even touch when it enacted ERISA.

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[34] The foregoing statistics are contained in or derived from the authorities cited in notes 3, 5, 9 & 10, *supra*.

We also note that, as mentioned earlier, by 1981 there were 855,000 employee welfare benefit plans. The persons insured under vast number of those plans would be left without protection.

4. Appellants claim there must be preemption because otherwise there will be lack of unformity in state laws that mandate particular forms of health insurance coverage. Their argument is addressed to the wrong forum. Congress specifically allowed nonuniformity when it expressly provided that laws regulating the business of insurance are saved from preemption. Congress knew insurance laws vary from state to state, but it saved them from preemption in deference to the long tradition of state regulation of insurance, a tradition which recognizes that in a federal system not all laws will be the same and not all laws should be made in Washington. If defendants object to the nonuniformity expressly contemplated by Congress, they should address their arguments to Congress instead of seeking judicial amendment of the statute.[35]

II. SECTION 47B IS NOT PREEMPTED BY THE NATIONAL LABOR RELATIONS ACT

Appellants assert that Section 47B is preempted by the National Labor Relations Act (NLRA).[36] The assertion is incorrect. There are no "persuasive reasons" for such

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[35] The only matter at issue here is whether ERISA preempts a state law requiring insurance companies to provide particular benefits in health insurance policies which they sell to others. A question *not* at issue is whether a state could require an employer to provide particular forms of health benefits to his own employees. Massachusetts appears to have conceded that, because of ERISA, a state could not require this. *Amici*, whose members include the political bodies and governing officials of many other states, do not agree with such a concession. In *Shaw v. Delta Air Lines, Inc.*, 103 S.Ct. 2890, 2905-6 (1983), the Court ruled that a state can require an employer to provide certain benefits separately from an ERISA plan, even if it cannot force him to include them in the ERISA plan itself. That logic is applicable to health benefits. Thus, if a state sought to require an employer to provide specific health benefits, it can do so even if it cannot require the benefits to be provided as part of an ERISA plan.

[36] 29 U.S.C. § 151 *et seq.*

preemption. To the contrary, there are persuasive reasons against it. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

Congress enacted the NLRA to remedy "the inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers who are organized in the corporate or other forms of ownership association. . ." 29 U.S.C. § 151. Section 47B, however, does not create any inequality of bargaining power. Moreover, at the time Congress enacted the NLRA, state regulation of insurance was long established, and Congress did not intend the NLRA to overturn this regulation. Indeed, Congress subsequently acted to assure the *continuation* of state regulation of insurance by passing the McCarran-Ferguson Act in 1945.[37] Finally, it is inconceivable that, in enacting the NLRA, Congress meant to deprive states of their historic power to protect the public health, a deprivation which would ensue if NLRA preempts state laws requiring insurers to provide important health benefits.

Nor is there preemption under the two tests this Court has often used in the labor field. Under the test laid down in *Garmon*,[38] there is no preemption if a state regulation deals with matters deeply rooted in local feeling and responsibility. Id. at 244. That is precisely the type of matter at issue here. As made clear earlier in this brief, Massachusetts, like other states, is deeply concerned that

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[37] The report of the House Committee on the Judiciary says that Congress was considering the Act "so that the several States may know that the Congress desires to protect the continued regulation and taxation of the business of insurance by the several States, and thus enables insurance companies to comply with State laws. What is more, the Congress proposes by this bill to secure adequate regulation and control of the insurance business." H. Rep. No. 143, 79th Cong., 1st Sess. (1945), reprinted in U.S. Code Cong. & Ad. News 670, 671.

[38] *San Diego Building Trades Council v. Garmon*, 359 U.S. 236 (1959).

millions of its citizens receive appropriate health insurance coverage and medical care and not be victimized by lack of coverage. It has, therefore, acted out of concern for the local public health. There is nothing more deeply rooted in local interest.

The second test, laid down in the *Machinists* case,[39] is that a state cannot regulate conduct which Congress left to the free play of economic forces. Id. at 140. The test is inapplicable here for two reasons. First, the test is correctly applied where a state seeks to affect an economic weapon (such as strikes) utilized by labor or management. *Machinists v. Wisconsin Employment Relations Commission*, 427 U.S. 132 (1976); *New York Telephone Co. v. New York State Dept. of Labor*, 440 U.S. 519 (1979). But laws like Section 47B are not intended to and do not affect any economic weapon employed by workers or management.

Second, in enacting NLRA, Congress did not intend to cause insurance or public health to be left to the "free play of economic forces" between labor and management. Rather, Congress preserved long-standing state regulation of insurance and also preserved the states' historic power to protect the public health.[40]

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[39] *Machinists v. Wisconsin Employment Relations Comm'n*, 427 U.S. 132 (1976).

[40] Like laws concerning torts or contracts, Section 47B is a neutral state law of general application. Numerous Justices have concluded that such laws are not preempted by the NLRA. *Belknap Inc. v. Hale*, 103 S. Ct. 3172, 3183 (1983) (White, J.); *Farmer v. Carpenters*, 430 U.S. 290, 296 (1977) (Powell, J.); *International Ass'n of Machinists v. Gonzales*, 356 U.S. 617, 619, 622 (1958) (Frankfurter, J.); *Linn v. United Plant Guard Workers*, 383 U.S. 53, 62 (1966) (Clark, J.); *New York Telephone Co. v. New York State Dept. of Labor*, 440 U.S. 519, 533 (1979) (Stevens, J.); *Taggart v. Weinacker's, Inc.*, 397 U.S. 223, 228 (1970) (Burger, C.J., concurring); *United Constr. Workers v. Laburnum Constr. Corp.*, 347 U.S. 656 (1954) (Burton, J.); *See* Cox, *Labor Law Preemption Revisited*, 85 Harv. L. Rev. 1337, 1355-1356, 1359-1360 (1972).

CONCLUSION

For the foregoing reasons, this Court should affirm the decision below that the Massachusetts law mandating mental health benefits in group insurance policies is not preempted.

Respectfully submitted,

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APPENDIX

McCarran-Ferguson Act

15 U.S.C. § 1012:

(a) The business of insurance and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Employee Retirement Income Security Act of 1974

29 U.S.C. § 1144:

"(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

"(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

"(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

"(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

"(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

"(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

"(c) For purposes of this section:

"(1) The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

"(2) The term 'State' includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

"(d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law."

Section 47B (Massachusetts Gen. Laws ch. 175 47B):

"Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in this commonwealth during the period that this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is promulgated or renewed to any person or group of persons in this commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requiremen :

"(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.

"(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

"(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) or subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve. For purposes of this clause 'psychotherapist' shall mean a person fully licensed to practice medicine under the provisions of chapter one hundred and twelve, who devotes a substantial portion of his time to the practice of psychiatry." Mass. Gen. Laws ch. 175, 47B.